Massachusetts Uncompensated Care Pool Surcharge Registration Form

1. Company contact information:

The Division of Health Care Finance and Policy will use the following information to direct payment notices and other correspondence regarding the Uncompensated Care Pool surcharge.

Company name: _____

Address: _____

_____

Contact person for surcharge issues: _____

Phone number: _____

Fax number: _____

Email: _____

2. Other names by which company is known:

List any names or initials, other than the one listed above, by which your company or your specific lines of business (e.g. "HMO Blue") are known to the health care providers to whom you make payments. Please note if any of these lines of business are solely Medicare or Medicaid risk products. (Use additional pages if needed.)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

3. Identification number:

Federal employer identification number (FEIN) (required for U.S. companies): _____

4. Type(s) of business: (check all that apply)

- ☐ Commercial Insurer
- ☐ Health Maintenance Organization
- ☐ Preferred Provider Organization
- ☐ Point of Service Plan
- ☐ Blue Cross Blue Shield
- ☐ Third Party Administrator that makes payments to hospitals and ambulatory surgical centers on behalf of self-insured plans
- ☐ Third Party Administrator that makes payments to hospitals and ambulatory surgical centers on behalf of insurance carriers
- ☐ Self-insured plan that makes direct payments to hospitals and ambulatory surgical centers
- ☐ Physician Hospital Organization
- ☐ Other, specify: _____

5. Third Party Administrators

If your company is a Third Party Administrator that makes payments to hospitals and ambulatory surgical centers on behalf of one or more insurance carriers, fill in the following information for each insurance carrier. Do not include information for self-insured plans on whose behalf you make payments. (Use additional pages if needed.)

A. Insurance Carrier name:_____

Other names by which company is known: _____

_____

Federal employer identification number (FEIN) (required for U.S. companies): _____

B. Insurance Carrier name:_____

Other names by which company is known: _____

_____

Federal employer identification number (FEIN) (required for U.S. companies): _____

6. Payment Information: (Complete this section if a third party will make payments)

Please provide the payer's name as it appears on check(s) issued for your monthly surcharge payments. (Use additional pages if needed.)

Payer's name: _____

Address: _____

Phone number: _____

Federal employer identification number (FEIN) (required for U.S. companies): _____

7. Signature:

I certify under pains and penalties of perjury that the above information is true and correct to the best of my knowledge.

_____ Signature

_____ Print name

_____ Date

_____ Title

Send completed forms to the Division of Health Care Finance and Policy:

FAX to: 617-727-7662

Or

MAIL to: Uncompensated Care Pool Surcharge Registration
Massachusetts Division of Health Care Finance and Policy
2 Boylston Street, Boston, MA 02116

If the information you need is not available on our web site or if you do not have access to the internet, call the Division at **800-888-2250**. You may also e-mail the Division at **pool.help@state.ma.us**.

For general information, please visit the EOHHS web portal at **www.mass.gov/dhcfp**.